Arapahoe County Sheriff's Office
Mortality Review Committee Report

December 29, 2014

Purpose: "To establish the procedures to be followed when the death of an inmate occurs in the Detention Facility. To ensure the responsible health authority determines that appropriateness of clinical care; ascertains whether corrective action in the system's policies, procedures, or practices is warranted; and identifies trends that require further study."
ACSO Policy DET 403

Report:

This committee met on December 23, 2014 and reviewed the following reported information:

1. The incident and facility procedures used:

On December 12, 2014, at 0756 hours, Mr. Lillis approached the medication cart during morning medication pass and informed the nurse that he was not feeling well. His temperature was 102.9, so the nurse had him transferred to the Inpatient unit for closer monitoring. At that time, the nurse initiated the Influenza-Like-Illness protocol.

After transfer to the Inpatient unit, the Inpatient nurse initiated the Respiratory Protocol, which added Saline Gargles for sore throat pain, as well as Tylenol, Mucinex and CTM to his medications.

On December 12, 2014, at 1651 hours, Mr. Lillis stated that he had chills, fever, congestion and a non-productive cough. Ibuprofen was provided, per the Headache Protocol.

On December 13, 2014, at 1511 hours, the nurse noted that Mr. Lillis was complaining of coughing and producing blood from coughing so hard. The provider on-call was notified and ordered medications that we do not have here; nor were able to get quickly. Those specific medications were not indicated in the medical record. Mr. Lillis was agitated with staff at that time. The staff instructed him to elevate the head of his bed. The nurse who documented that medications were not available confirmed that the on-call provider was Dr. [redacted] and that the medications he ordered were Robitussin DMX and Robitussin with Codeine. That nurse had communicated with Dr. [redacted] that Mr. Lillis had "blood-tinged" sputum, (as opposed to "producing blood"; which had been documented); that looked like he had produced a small amount of blood from coughing so hard.

On December 13, 2014, at 1732 hours, the nurse noted observation of Mr. Lillis during the 1600 medication pass. It appeared the coughing had slowed down, but was still present. Mr. Lillis complained of a headache, at that time.

On December 14, 2014, at 1618 hours, the nurse noted that, during the morning medication pass, Mr. Lillis complained of weakness, sore throat, coughing and fever for the past four days. His vital signs were within normal limits, at that time, with an elevated pulse of 121. Upon evaluation, his throat was noted to be red, with no exudates or lymphadenopathy. Mr. Lillis was instructed to continue increased fluid intake and rest.

On December 14, 2014, during the evening shift medication pass (exact time unknown); Mr. Lillis called for nurse, stating he was not feeling well. He told the deputy that he had, "liver pain". The nurse finished up her medication pass and the deputy stated that he "looked sick" when the deputy brought Mr. Lillis his dinner tray. The nurse responded to check his vitals, but could not obtain them because Mr. Lillis was moving vigorously and would not sit still. Mr. Lillis stated that he needed his anxiety medications. The nurse stated that there was no anxiety medication ordered for him at this time and he responded that he needs to be started on a withdrawal protocol. Mr. Lillis stated that he had coughed up blood. The nurse left Mr. Lillis with a basin and asked him to cough up into that basin, so she could evaluate his condition better. She also offered Mr. Lillis some Gatorade. At 1930, the deputy watching the cameras reported that Mr. Lillis had fallen off of the toilet. Upon review of the camera, it appeared that Mr. Lillis was crawling to his bed and positioned himself onto his left side. At 1941, the nurse asked the deputy to accompany her so she could, once again, attempt to obtain his vitals. Upon approach, the nurse noticed blood coming out of his mouth. She assessed Mr. Lillis and found no pulse and no respirations. The nurse immediately started compressions. The medical emergency was called at 1943 hours. Compressions continued and the AED was initiated. South Metro responded and continued with CPR until they decided to discontinue resuscitative methods. An EMT with South Metro contacted the doctor at Sky Ridge who pronounced Mr. Lillis dead at 2009 hours.